KEVIN V. RYAN (CASBN 118321)
United States Attorney

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

SAN JOSE DIVISION

UNITED STATES OF AMERICA,

Plaintiff,

v.

NEIL PHILIP McARTHUR,

Defendant.

CR No. 04 20207 JF RS

VIOLATIONS: 18 U.S.C. § 371 – Conspiracy to Commit Health Care Fraud; 18 U.S.C. § 1347 – Health Care Fraud; 18 U.S.C. § 1035 – False Statements Relating to Health Care Matters

SAN JOSE VENUE

INDICTMENT

The Grand Jury charges:

OVERVIEW

1. This indictment alleges a conspiracy to defraud Medicare committed by the defendant, Neil Philip McArthur, and others, on behalf of Monterey Family Practice Medical Center (MFP), a medical practice formerly located at 1010 Cass Street, Suite D-4, Monterey, California, with its administrative offices located at 2555 Garden Road, Suite 102, Monterey, California. Beginning no later than January 1, 1998 and continuing through January 6, 2000, the defendant, while employed as the office administrator for

MFP, defrauded the United States by knowingly submitting false and fraudulent bills to Medicare for medical services that had not been rendered, were rendered by unlicensed or unqualified personnel, and for services that had been "upcoded" to reflect a more expensive procedure than was actually performed. An audit conducted by the National Heritage Insurance Corporation estimates the total fraud committed on behalf of MFP to have been over $800,000 between January 1, 1998 and December 31, 1999.

THE DEFENDANT AND OTHER PARTIES

2. Neil Philip McArthur ("McArthur"), age 52, of Monterey, California, was employed by MFP from 1995 to January 6, 2000.

3. MFP was a California corporation consisting of a number of physicians practicing in the Monterey area. Doctors Karen Tierney, James Vawter, Cindy Lee, and Jay Edmunds served, at various times, on the board of directors of MFP, which existed as a California corporation until approximately November 2002.

4. Alpha Healthcare Management Services, LLC ("Alpha") was the billing services company for MFP and other physicians' groups. Its offices were located at 2555 Garden Road, Suite 102, Monterey, California. MFP purchased Alpha (formerly known as Direct Connect) in September 1997, but continued to operate it as a separate entity. McArthur worked for both Alpha and MFP, and handled billing services for MFP.

5. Monterey Medical Center (MMC) was a California corporation consisting of physicians from MFP and another medical group. MMC operated an urgent and evening care facility. In an application for a Provider Identification Number dated November 13, 1995, MMC listed its physical address as 1010 Cass Street, Monterey, California. Dr. James Vawter of MFP was listed as the president of MMC. McArthur also handled billing services for MMC.

BACKGROUND REGARDING THE MEDICARE PROGRAM

At all times relevant to this indictment:

6. The Social Security Act (Title 42, United States Code, Sections 301 *et seq.*) was in full force and effect and had established the Medicare Part B Program (under

subchapter XVIII of Chapter Seven of that Act) which provided for supplementary medical insurance benefits for persons aged 65 years and older who were entitled to Social Security benefits.

7. Medicare Part B reimbursed 80% of the reasonable charge of most medically necessary services performed, ordered or appropriately supervised by a licensed medial practitioner. Medicare paid and processed claims and remitted payment from its contractor, the National Heritage Insurance Corporation (NHIC) located in Chico, California.

8. Licensed medical providers filled out an application form with Medicare in order to be assigned a provider number. It was that Unique Physician Identification Number, or UPIN, that was used to submit billings to Medicare for reimbursement and identified the provider who rendered the services. Medicare providers agreed to abide by all Medicare laws, regulations, and program instructions.

9. The remaining 20% of the charges referred to in paragraph B were either paid by the Medicare enrollee, a supplemental private insurer, or by the State of California's Medi-Cal Program.

10. TRICARE, formerly known as CHAMPUS, was a federal government program under the auspices of the Department of Defense that provided health care for the families and other dependents of the United States military. All billings to TRICARE during the period covered by this indictment for services rendered in California were sent for processing and check generation to Palmetto GBA, Surfside Beach, South Carolina. Palmetto Government Benefits Administrators processed the claims under sub-contract to Health Net Federal Services, which operated under contract from the Department of Defense to administer the TRICARE program in California.

11. A "superbill" is a document filled out by a physician or nurse after a patient visit. It lists the most common treatments and diagnoses, as well as levels of service, each of which is identified by a unique number, or "code." A superbill thus provides a shorthand way for the treatment provider to describe the services and diagnoses rendered.

The superbill is in turn used by the physician's administrative staff to submit a claim for reimbursement to Medicare or other insurance provider.

THE SCHEME TO DEFRAUD

12. From a date unknown to the grand jury, but beginning no later than January 1, 1998, to and including January 10, 2000, in the Northern District of California, the defendant Neil Philip McArthur, and others, conspired to execute and did execute a scheme and artifice to defraud a health care benefit program, which program affected interstate commerce, namely, the defendant billed, and caused to be billed, Medicare and TRICARE for physical therapy, diagnostic tests, and other physician services that had not been rendered, had been rendered by unlicensed or unqualified personnel, and for services that had been "upcoded" to reflect a more expensive procedure than was actually performed. As a result of this scheme, during the time period covered by this indictment, the defendant defrauded Medicare and TRICARE by an amount exceeding $800,000.

HOW THE SCHEME WORKED

In furtherance of the scheme to defraud, McArthur and other unindicted co-conspirators did and caused to be done the following:

13. McArthur "upcoded" superbills using a marker. He took the superbills filled out by the individual MFP physicians and changed the codes to reflect more expensive procedures and services. McArthur did so without reviewing the patient's medical chart and without consulting with the attending physician or anyone else with direct knowledge. McArthur therefore revised the superbills without knowing what services and procedures had actually been performed.

14 McArthur added procedures, such as x-rays, urinalyses, and EKGs, to superbills without confirming, either by referring to the patient's medical chart or by consulting with the attending physician or anyone else with direct knowledge, that those procedures had in fact been performed.

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15. McArthur also fraudulently billed "kinetic therapy" (massage) visits as physical therapy visits. McArthur also fraudulently billed physical therapy patients under the Unique Physician Identification Number (UPIN) assigned to Dr. Paul Tocchet, a member of MFP, without Dr. Tocchet's knowlege or consent.

COUNT ONE: 18 U.S.C. § 371 (Conspiracy to Commit Health Care Fraud)

16. The factual allegations contained in paragraphs 1 through 15 of this Indictment are realleged and incorporated as if fully set forth here.

17. Beginning on a date unknown to the grand jury, but no later than January 1, 1998, through and including January 10, 2000, in the Northern District of California, and elsewhere, the defendant

NEIL P. McARTHUR,

and others, did knowingly and wilfully conspire to commit an offense against the United States, namely, health care fraud, in violation of Title 18, United States Code, Section 1347.

OVERT ACTS IN FURTHERANCE OF THE CONSPIRACY

18. In furtherance of the conspiracy and to effect the objects thereof, McArthur and others committed, and caused to be committed, the following overt acts in furtherance of the conspiracy:

19. McArthur directed employees of MFP and Alpha to collect superbills and deliver them to him at his apartment at 125 Surf Way.

20. **April 30, 1998 Medicare Claim for Patient V.L.** On or about April 30, 1998, McArthur falsely and fraudulently upcoded, double-billed, and added procedures to a superbill for a patient identified by her initials V.L. for a visit that, according to the superbill, took place on April 30, 1998 at 3:00 p.m., purportedly with Dr. Davis. The service was submitted to Medicare under two separate claim numbers (0298128416530 and 0298128416540). Medicare paid this claim on or about May 20, 1998.

a. Bills Upcoded. A review of the patient's file by NHIC showed that the appropriate level of service for V.L's visit was E & M code 99212 (less-complex

office visit), which would be reimbursed by Medicare in the amount of $22.43. McArthur upcoded this bill to E & M code 99213 (mid-complexity office visit), thereby increasing the reimbursement amount. In truth and in fact, as the defendant well knew, and wilfully disregarded, there was no "mid-complexity" office visit with V.L. on that date.

b. Double Billing and Billing for Procedures Not Performed. For the same office visit, McArthur falsely and fraudulently submitted a second, separate claim for reimbursement to Medicare showing E & M code 99214 (higher-complexity office visit), claiming reimbursement of $48.15. On this duplicate bill, McArthur also added E & M procedure codes 73030 (upper extremity x-ray; claimed reimbursement $24.19) and 73562 (lower extremity x-ray; claimed reimbursement $25.20). In truth and in fact, as the defendant well knew, and wilfully disregarded, neither x-ray procedure was performed on that date.

21. **Seven Visits to Patient H.H. Fraudulently Billed to Medicare as if Made by Doctor Were in Fact Made by Nurse Practitioner.** On seven dates between December 3, 1998 and February 11, 1999, McArthur falsely and fraudulently billed Medicare for services as if they had been performed by a doctor when, as he well knew, and wilfully disregarded, those services were done by a nurse practitioner. On each occasion, McArthur billed Medicare as if Dr. Tocchet had visited patient H.H. at the Sunrise skilled nursing facility when, in fact, a nurse practitioner had made each of the visits. The result in each case was an overcharge to Medicare. For example, McArthur billed Medicare $66.83 for a mid-complexity patient visit to a skilled nursing facility (E & M code 99313), purportedly made by Dr. Tocchet to patient H.H. on December 3, 1998. Medicare paid the claim on or about December 30, 1998. McArthur knowingly submitted similarly fraudulent bills for visits to patient H.H. at the Sunrise nursing facility on the following additional dates: December 10, 1998; December 17, 1998; January 3, 1999; January 19, 1999; February 4, 1999; and February 11, 1999. Each additional claim was paid by Medicare as if Dr. Tocchet had visited the patient.

22. **June 16-17, 1999 Medicare Claim for Patient W.N.** On or about June 17, 1999, McArthur falsely and fraudulently billed Medicare for services that had not been performed. MFP billed Medicare for high-complexity hospital visits (E & M code 99233) to patient W.N. by Dr. Tapson on June 16 and 17, 1999. Medicare paid the claims on or about July 19, 1999. W.N. was in fact admitted to the Community Hospital of the Monterey Peninsula (CHOMP) on June 15 and discharged on June 18, 1999, and was visited by Dr. Tapson on each of those two dates. In truth and in fact, however, as the defendant well knew, and wilfully disregarded, there were no high-complexity hospital visits by Dr. Tapson to W.N. on either June 16 or 17, 1999.

23. **September 17, 1999 Medicare Claim for Patient W.N.** On or about September 17, 1999, McArthur falsely and fraudulently billed Medicare $64.69 for a "higher-complexity" office visit (E & M code 99214) with patient W.N., purportedly by Dr. Daly. Medicare paid the claim on or about October 6, 1999. In truth and in fact, as the defendant well knew, and wilfully disregarded, there was no "higher-complexity" office visit with W.N. on that date.

24. **October 25, 1999 for Patient J.W.** On or about October 25, 1999, McArthur falsely and fraudulently billed Medicare for services as if they had been performed by a doctor when, in truth and in fact, as the defendant well knew, and wilfully disregarded, they were performed by a nurse practitioner. MFP billed Medicare $120.42 for a moderate-to-high complexity visit (E & M code 99303) by Dr. Tocchet to patient J.W. at the Monterey Pines skilled nursing facility. Medicare paid the claim on or about November 22, 1999.

25. **December 8, 1999 Medicare Claim for Patient M.P.** On or about December 8, 1999, McArthur falsely and fraudulently billed Medicare $64.69 for a "higher-complexity" office visit (E & M code 99214) with patient M.P., purportedly by Dr. Carnazzo. Medicare paid the claim on or about January 10, 2000. In truth and in fact, as the defendant well knew, and wilfully disregarded, there was no "higher-complexity" office visit with M.P. on that date.

All in violation of Title 18, United States Code, Sections 371and 1347.

COUNT TWO: 18 U.S.C. § 1347 (Health Care Fraud)

26. The factual allegations contained in paragraphs 1 through 15 and ~~16~~ 19 - ~~25~~ through 25 of this Indictment are realleged and incorporated as if fully set forth here.

27. On or about and between a date unknown to the grand jury, but beginning no later than January 1, 1998, through and including January 10, 2000, in the Northern District of California, and elsewhere, the defendant

NEIL P. McARTHUR,

did knowingly and willfully execute, and attempt to execute, a scheme and artifice to defraud a health care benefit program, namely, Medicare, in connection with the delivery of and payment for health care benefits, items, and services, in violation of Title 18, United States Code, Section 1347.

COUNT THREE: 18 U.S.C. § 1035 (False Statements Relating to Health Care Matters)

28. The factual allegations contained in paragraphs 1 through 15 and ~~16~~ 19 through 25 of this Indictment are realleged and incorporated as if fully set forth here.

29. On or about December 8, 1999, in the Northern District of California, and elsewhere, the defendant,

NEIL P. McARTHUR,

did, in a matter involving a health care benefit program, namely, Medicare, knowingly and wilfully make a materially false, fictitious, and fraudulent statement and representation, and did make and use a materially false writing and document knowing the same to contain a materially false, fictitious, and fraudulent statement and entry, in connection with the delivery of and payment for health care benefits, items, and services.

30. Specifically, on or about December 8, 1999, McArthur billed Medicare $64.69 for a "higher-complexity" office visit (E & M code 99214) with patient M.P., purportedly by Dr. Carnazzo. Medicare paid the claim on or about January 10, 2000. In truth and in fact, as the defendant well knew, and wilfully disregarded, there was no

"higher-complexity" office visit with M.P. on that date and no evidence of such a visit.

All in violation of Title 18, United States Code, Section 1035.

ENHANCEMENT ALLEGATIONS

31. With respect to each count, the actual loss attributable to McArthur's scheme to defraud was more than $800,000 but not more than $1,500,000.

32. With respect to each count, the offense involved more than minimal planning.

DATED: 12-1-04

A TRUE BILL.

FOREPERSON

KEVIN V. RYAN
United States Attorney

MATTHEW A. PARRELLA
Branch Chief, San Jose

(Approved as to form: AUSA Callaway)